STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155203	A. BUILDING 02 B. WING	10/31/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CENTRE FOR HEALTH AND REHABILITATION	203 SPARKS AVE JEFFERSONVILLE, IN47130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 10/31/11 Facility Number: 000110 Provider Number: 155203 AIM Number: 100271120 Surveyor: Mark Bugni, Life Safety Code Specialist At this Life Safety Code survey, Hillcrest Centre for Health and Rehabilitation was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. Hillcrest Centre for Health and Rehabilitation is a two story building with a finished partial basement constructed at two different times. The original building was built in 1966 and constructed with mixed construction consisting of a two	K0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. This plan of correction will be completed on or before November 30 th , 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	and one half inch thick concrete decks separating each floor, one hour fire rated smoke barrier walls, two fire barrier walls constructed of two hour construction on each level, brick exterior walls with metal studs and one half hour rated drywall, a mix of concrete and metal stud interior walls with one half hour rated drywall, and metal trusses and wooden rafters in the roof assembly. Based on the lowest construction type, the facility construction type was classified as Type V (111) construction. The original building was built with an open column foundation exposed at the entire south length of the facility. In 1974, a two story addition including the level 1 Transcare Unit and level 2 East Wing was constructed to the southeast of the original building and the column foundation was converted into a poured finished partial basement for physical therapy and is also of Type V (111) construction. Because the original building and the addition are the same type of construction, the facility was surveyed as one building. The facility is fully sprinklered. The facility has a fire alarm system with smoke detection on all levels including the corridors and spaces open to the corridors. The facility has a capacity of 180 and had a census of 77 at the time of this survey.			

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	Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/04/11. The facility was found not in compliance with the aforementioned regulatory requirement as evidenced by the following:			
K0018 SS=E	Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 5 of 163 corridor doors would latch and resist the passage of smoke with no impediment to closing the doors. This deficient practice affects any residents using the first floor beauty shop in the Service Hall where the mechanical room is located, 2 residents who reside in room 149, 2 residents in room 319, and any resident using the main dining room located adjacent to the kitchen. Findings include:	K0018	**K018** Require that a facility has: Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by	11/30/2011

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	Based on observations on 10/31/11 during a tour of the facility from 8:00 a.m. to 1:10 p.m. with the maintenance supervisor and administrator, the room doors to the first floor Service Hall mechanical room, resident room 149, resident room 319, and the kitchen each had a one inch gap along the top and latching sides of the doors. Furthermore, resident room door 149 failed to latch into the door frame. This was verified by the maintenance supervisor and administrator at the time of observations. 3.1-19(b)		CMS regulations in all health care facilities. The facility will ensure this requirement is met through the following: 1. No residents were harmed. The doors in the Service Hall mechanical room, resident room 149 and 319, and the main dining room doors located adjacent to the kitchen have all been repaired of 1 inch gaps. Additionally, room 149 door latch was repaired. 2. All residents have the potential to be affected. Facility inspected to ensure no further areas of concern. 3. Maintenance staff in-serviced on K018. 4. The Administrator or designee will utilize the Interior Preventative Maintenance Monitoring Tool monthly times 3 months and then Quarterly until compliance has been maintained for 2 consecutive quarters (See Attachment A). The audits will be reviewed during the facilities quality assurance meeting and issues Will be addressed and the above plan will be altered accordingly, if needed. 5. The above plan of correction will be completed on or before November 30, 2011.	
K0020 SS=E	Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. Based on observation and interview, the facility failed to ensure 1 of 4 vertical	K0020	**K 020** Requires that a facility has: Stairways, elevator shafts, light and ventilation shafts, chutes,	11/30/2011

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	openings was enclosed with construction having at least a one hour fire resistance. LSC 19.3.1.1 requires any vertical opening to be enclosed or protected in accordance with LSC 8.2.5. LSC 8.2.5.4 refers to 7.1.3.2.1 for enclosure of exits. LSC 7.1.3.2.1 requires openings in the separation be protected by fire door assemblies equipped with door closers complying with 7.2.1.8. NFPA 80, the Standard for Fire Doors and Fire Windows at 2-1.2 requires fire door assemblies to include latches. NFPA 80, 2-1.4 requires fire doors to be closed and latched at the time of fire. This deficient practice could affect 34 residents who reside on the second floor and could use the 1 West Hall stairway door during an evacuation. Findings include: Based on observation on 10/31/11 at 8:30 a.m. with the maintenance supervisor and administrator, the 1 West stairway door leading to the second floor was not provided with latching hardware to allow the door to latch and close in the door frame. This was verified by the maintenance supervisor and administrator at the time of observation. 3.1-19(b)		and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. The facility will ensure this requirement is met through the following: 1. No residents were harmed. A self-closing latch was installed to the 1 West stairway door. 2. All residents have the potential to be affected. Facility inspected to ensure no further areas of concern. 3. Maintenance staff in-serviced on K020. 4. The Administrator or designee will utilize the Interior Preventative Maintenance Monitoring Tool monthly times 3 months and then Quarterly until compliance has been maintained for 2 consecutive quarters (See Attachment A). The audits will be reviewed during the facilities quality assurance meeting and issues Will be addressed and the above plan will be altered accordingly, if needed. 5. The above plan of correction will be completed on or before November 30, 2011.	

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K0025 SS=E	Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 1. Based on observations and interview, the facility failed to ensure 4 of 8 attic smoke barriers were constructed to provide at least a one half hour fire resistance rating. This deficient practice affects 45 residents who reside on the first floor. Findings include: Based on observations with the maintenance supervisor and administrator on 10/31/11 during observation of the attic smoke barriers from 11:10 a.m. to 12:40 p.m., the following attic smoke barrier walls above smoke barrier doors had penetrations fire stopped with unrated expandable foam insulation: a. The 1 West Hall smoke barrier wall had sixteen, one inch to four inch areas firestopped with unrated expandable foam insulation. b. The 1 East Hall smoke barrier wall had twenty one, one inch to four inch areas	K0025	**K 025** Requires that a facility has: Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. The facility will ensure this requirement is met through the following: 1. No residents were harmed. All areas identified as a concern were replaced with rated, expandable foam	11/30/2011

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	firestopped with unrated expandable foam insulation. c. The first floor Transcare Hall nurses' station smoke barrier wall had twenty six, one inch to four inch areas firestopped with unrated expandable foam insulation. d. The first floor Transcare Hall smoke barrier by room 125 had twenty seven, one inch to four inch areas firestopped with unrated expandable foam insulation. Based on an interview with the maintenance supervisor on 10/31/11 at 12:40 p.m., the first floor smoke barriers were firestopped with unrated expandable foam insulation. This was verified by the administrator at the 1:00 p.m. exit conference on 10/31/11.. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 163 room wall smoke barriers were continuous through all concealed spaces including interstitial spaces. 8.3.2 states smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. This deficient practice could affect 2 residents		installation including: a. The 16 areas of the 1 West Hall smoke barrier wall. b. The 21 areas of the 1 East Hall smoke barrier wall. c. The 26 areas of the first floor Transcare Hall nurses' station smoke barrier wall. d. The 25 areas of the first floor Transcare Hall smoke barrier by room 125. A rated, expandable foam was used to create a continuous smoke barrier for the first floor respiratory office east wall and the west wall of resident room 314. 2. All residents have the potential to be affected. Facility inspected to ensure no further areas of concern. 3. Maintenance staff in-serviced on K025. 4. The Administrator or designee will utilize the Interior Preventative Maintenance Monitoring Tool monthly times 3 months and then Quarterly until compliance has been maintained for 2 consecutive quarters (See Attachment A). The audits will be reviewed during the facilities quality assurance meeting and issues will be addressed and the above plan will be altered accordingly, if needed. 5. The above plan of correction will be completed on or before November 30, 2011.	

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	who reside in room 314 and any resident using the respiratory therapy office. Findings include: Based on observation with the maintenance supervisor and administrator during a tour of the facility from 8:00 a.m. to 1:10 p.m. on 10/31/11, the first floor respiratory therapy office east wall had a three inch by three inch area of drywall missing exposing the steel studs and space between. Additionally, resident room 314 west wall had a four inch by four inch area of drywall missing exposing the steel studs and the space between. This was verified by the maintenance supervisor and administrator at the time of observations. 3.1-19(b)			
K0027 SS=E	Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 7 sets of smoke barrier doors would restrict the	K0027	**K 027** Requires that a facility has: Door openings in smoke barriers	11/30/2011

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	movement of smoke for at least 20 minutes. LSC, Section 19.3.7.6 requires doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect 15 residents who reside on the second floor West Hall. Findings include: Based on observation with the maintenance supervisor and administrator on 10/31/11 at 11:45 a.m., the second floor West Hall set of smoke barrier doors near the nurses' station did not close completely, leaving a two inch gap between the doors. This was verified by the maintenance supervisor and administrator at the time of observation. 3.1-19(b)		have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, The facility will ensure this requirement is met through the following: 1. No residents were harmed. The identified area of concern on the second floor, West Hall smoke barrier door was corrected. 2. All residents have the potential to be affected. Facility inspected to ensure no further areas of concern. 3. Maintenance staff in-serviced on K027. 4. The facility Fire Drill check off sheet was updated to include the inspection of the fire doors for gaps at the time of the facility monthly fire drill (See attachment B). 5. The Administrator or designee will review the monthly Fire Drill	

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			Report each month to ensure compliance is being maintained. 6. The above plan of correction will be completed on or before November 30, 2011.	
K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridor doors to 4 of 17 hazardous areas, such as a combustible storage rooms over 50 square feet in size, were provided with self closing devices which would cause the doors to automatically close and latch into the door frames. This deficient practice could affect 12 residents who reside on the second floor 400 Hall. Findings include: Based on observations on 10/31/11 during a tour of the facility from 8:00 a.m. to 1:10 p.m. with the maintenance supervisor and administrator, the corridor doors to the first floor housekeeping	K0029	**K 029** Requires that a facility has: One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	11/30/2011

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	closet next to room 112, the second floor room 412, the second floor room 201, and the basement storage room which each measured from one hundred seventeen square feet to one hundred eighty square feet and stored cardboard boxes of paper supplies, paper towels, and wooden shelves, each lacked a self closing device. This was verified by the maintenance supervisor and administrator at the time of observations. 3.1-19(b)		The facility will ensure this requirement is met through the following: 1. No residents were harmed. Self-closing devices were installed on the corridor doors that were identified as a concern including; the first floor house-keeping closet next to room 112, the second floor housekeeping closet next to 412, the second floor room 201, and the basement storage room. 2. All residents have the potential to be affected. Facility inspected to ensure No further areas of concern. 3. Maintenance in-serviced on K029. 4. The Administrator or designee will utilize the Interior Preventative Maintenance Monitoring Tool monthly times 3 months and then Quarterly until compliance has been maintained for 2 consecutive quarters (See Attachment A). The audits will be reviewed during the facilities quality assurance meeting and issues will be addressed and the above plan will be altered accordingly, if needed. 5. The above plan of correction will be completed on or before November 30, 2011.	
K0038 SS=E	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1			

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	1. Based on observation and interview, the facility failed to ensure 5 of 6 exit accesses supplied with delayed egress locks were provided with a sign indicating PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. 7.2.1.6.1, requires approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor be required to be continuously applied for	K0038	**K 038** Requires that a facility has: Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 The facility will ensure this requirement is met through the following: 1. No residents were harmed. Signs that read “Push Until Alarm Sounds Door Can Be Opened in 15 Seconds” was installed on doors identified as a concern. This includes; the first floor service hall exit, the two Administration Hall front exits, and the two Administration Hall side exits. Codes to the second floor stairway exits will be posted on the 3 doors identified as a concern, which include; the 2 East stairway door, the 2 West Stairway door, and the 2 South stairway doors. 2. All residents have the potential to be affected. Facility inspected to ensure no other areas of concern. 3. Maintenance staff in-serviced on K038. 4. The Administrator or designee will utilize the Interior Preventative Maintenance Monitoring Tool monthly times 3 months and then Quarterly until compliance has been maintained for 2 consecutive quarters (See Attachment A).	11/30/2011

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	more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay no exceeding 30 seconds shall be permitted. (d) On the door adjacent to the releasing device, there shall be a readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. This deficient practice affects all residents in the facility. Findings include: Based on observations on 10/31/11 during a tour of the facility with the maintenance supervisor and administrator from 8:00 a.m. to 1:10 p.m. the first floor Service Hall exit, the two Administration Hall front exits, and the two Administration Hall side exits were each equipped with delayed egress locks which unlocked the magnetic hold down device after pressure was applied for ten seconds to the door latching hardware. Furthermore, the five exit doors were not provided with a sign		The audits will be reviewed during the facilities quality assurance meeting and issues will be addressed and the above plan will be altered accordingly, if needed. 5. The above plan of correction will be completed on or before November 30, 2011.	

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	indicating PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. This was verified by the maintenance supervisor and administrator at the time of observations. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 3 of 3 second floor stairway exits were readily accessible at all times. LSC 7.2.1.5.1 requires doors shall be arranged to be opened readily from the egress side whenever the building is occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. This deficient practice affects 34 residents who reside on the second floor and would use the 2 East, 2 West and 2 South stairway exits during an evacuation. Findings include: Based on observations on 10/31/11 during a tour of the facility from 8:00 a.m. to 1:10 p.m. with the maintenance supervisor and administrator, the second floor 2 East stairway exit, 2 West stairway exit, and 2 South stairway exit were each provided with a push button coded door lock. Based on an interview with the maintenance supervisor on 10/31/11 at			

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	12:45 p.m., the 2 East, 2 West and 2 South stairway exit door lock combinations are not given to residents. Staff are the only people who know the door locking combination. Furthermore, on 10/31/11 at 1:00 p.m., when the fire alarm system was tested, the 2 East, 2 West, and 2 South stairway exit doors did not unlock to open when the fire alarm system was activated. The 2 East, 2 West, and 2 south stairway exit door locking combinations only know by staff was acknowledged by the administrator at the 1:10 p.m. exit conference on 10/31/11.. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure the means of egress through 3 of 3 second floor stairway exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety,			

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	provided that staff can readily unlock such doors at all times. This deficient practice affects 34 residents who reside on the second floor and would use the 2 East, 2 West and 2 South stairway exits during an evacuation. Findings include: Based on observations on 10/31/11 during a tour of the facility from 8:00 a.m. to 1:10 p.m. with the maintenance supervisor and administrator, the second floor 2 East stairway exit, 2 West stairway exit, and 2 South stairway exit were each provided with a push button coded door lock. Based on an interview with the maintenance supervisor and administrator on 10/31/11 at 12:45 p.m., the 2 East, 2 West and 2 South stairway exit door lock combinations are not given to residents and staff are the only people who know the door locking combination and there are no residents who reside on the second floor 2 East, 2 West and 2 South Halls with a clinical diagnosis to be in a secure building. Furthermore, on 10/31/11 at 1:00 p.m., the fire alarm system was tested and the 2 East, 2 West, and 2 South stairway exit doors were not electrically wired to open when the fire alarm system was activated. The 2 East, 2 West, and 2 south stairway exit door locking combinations only know by staff was			

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	acknowledged by the administrator at the 1:10 p.m. exit conference on 10/31/11. 3.1-19(b)			
K0045 SS=E	Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 Based on observation and interview, the facility failed to ensure the lighting for 1 of 10 exit means of egress was arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness. This deficient practice could affect any residents, as well as staff, and visitors using the basement physical therapy room. Findings include: Based on observation on 10/31/11 at 12: 10 p.m. with the maintenance supervisor and administrator, the physical therapy west exit was equipped with a dual light fixture with only one bulb. Based on interview at the time of observation, the maintenance supervisor acknowledged the basement physical therapy west exit dual light fixture with one bulb. 3.1-19(b)	K0045	**K 045** Requires that a facility has: Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 The facility will ensure this requirement is met through the following: 1. No residents were harmed. The light fixture identified as an area of concern was equipped with 2 light bulbs. 2. All residents have the potential to be affected. Facility inspected to ensure no other areas of concern. 3. Maintenance staff in-serviced on K045. 4. The Administrator or designee will utilize the Interior Preventative	11/30/2011

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			Maintenance Monitoring Tool monthly times 3 months and then Quarterly until compliance has been maintained for 2 consecutive quarters (See Attachment A). The audits will be reviewed during the facilities quality assurance meeting and issues will be addressed and the above plan will be altered accordingly, if needed. 5. The above plan of correction will be completed on or before November 30, 2011.	
K0048 SS=F	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to include the kitchen K class portable fire extinguisher in the written plan for the protection of 77 of 77 residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice affects all residents	K0048	**K 048** Requires that a facility has: There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 The facility will ensure this requirement is met through the following: 1. No residents were harmed. The facility Fire Plan (Attachment C) was reviewed and amended to include types of fire extinguishers and their usage. Additionally, the statement was added under the K extinguisher, "In the event of a fire in the kitchen, staff should first use the hood fire suppression system and the K Fire Extinguisher should only be utilized as a secondary	11/30/2011

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	in the facility. Findings include: Based on a review of the facility's written Fire Disaster Plan on 10/31/11 at 12:20 p.m. with the maintenance supervisor and administrator, the Fire Disaster Plan did not address the use of the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. This was verified by the administrator at the time of record review. 3.1-19(b)		means". 2. All residents have the potential to be affected. 3. Facility staff in-serviced on or before November 30, 2011. 4. The Administrator or designee will utilize the Interior Preventative Maintenance Monitoring Tool monthly times 3 months and then Quarterly until compliance has been maintained for 2 consecutive quarters (See Attachment A). The audits will be reviewed during the facilities quality assurance meeting and issues will be addressed and the above plan will be altered accordingly, if needed. 5. The above plan of correction will be completed on or before November 30, 2011.	
K0050 SS=F	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on interview and record review, the facility failed to conduct quarterly fire drills on each shift for 2 of 4 quarters. This deficient practice affects all occupants in the facility including staff, visitors and residents.	K0050	**K 050** Requires that a facility has: Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established	11/30/2011

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	Findings include: Based on review of Fire Drill Reports with the maintenance supervisor and administrator on 10/31/11 at 12:45 p.m., a fire drill was not documented for the second and third shifts of the third quarter of 2011 or for the first shift and third shift of the fourth quarter of 2010. Additionally, based on interview with the maintenance supervisor and administrator during the review of the Fire Drill Reports, there was no other documentation available for review to verify these drills were conducted. 3.1-19(b) 3.1-51(c)		routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 The facility will ensure this requirement is met through the following: 1. No residents were harmed. Fire Drill was conducted (See Attachment D). 2. All residents have the potential to be affected. 3. The Maintenance Director or designee will utilize the Fire Drill "Tentative" Schedule planning form to plan monthly fire drills (See Attachment E). 4. Maintenance staff in-serviced on K050. 5. The Administrator or designee will review the monthly Fire Drill Report each month to ensure compliance is being maintained. The monthly review will be on-going (See Attachment B). 6. The above plan of correction will be completed on or before November 30, 2011.	

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K0051 SS=C	A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the schedules in Chapter 7 or more often if required by the authority having jurisdiction. Table 7-3.2 shall apply. Table 7-3.2 "Testing Frequencies" requires alarm initiating devices, alarm notification appliances, batteries, and initiating devices to be tested at least annually. This deficient practice could affect all residents, staff and visitors.	K0051	**K 051** Requires that a facility has: A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the	11/30/2011

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	Findings include: Based on review of the facility's Koorsen Fire Alarm System Inspection and Testing Reports Quarterly on 10/31/11 at 12:00 p.m., the quarterly report showed a service date of 07/27/11 on the first page of the report. The second page of the report showed the service date of 08/11/11 and the third page of the report showed a service date of 07/11/11. Based on an interview with the maintenance supervisor on 10/31/11 at 12:15 p.m., the quarterly fire alarm system report dates are confusing and it is not clear what date the quarterly fire alarm system inspection was conducted. 3.1-19(b)		path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, The facility will ensure this requirement is met through the following: 1. No residents were harmed. Koorseen Fire and Security inspected the system with no problems noted (See Attachment F). 2. All residents have the potential to be affected. No further areas of concern noted. 3. Preventative Maintenance Fire Alarm/Smoke Detectors Equipment Record reviewed with no changes made (See Attachment G). 4. Maintenance staff in-serviced on K051. 4. The Administrator or designee will utilize the Interior Preventative Maintenance Monitoring Tool monthly times 3 months and then Quarterly until compliance has been maintained for 2 consecutive quarters (See Attachment A). The audits will be reviewed during	

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			the facilities quality assurance meeting and issues will be addressed and the above plan will be altered accordingly, if needed. 5. The above plan of correction will be completed on or before November 30, 2011.	
K0052 SS=E	A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on observation and interview, the facility failed to ensure 2 of 17 manual fire alarm boxes were mounted at the correct height. NFPA 72, 1999 Edition of the National Fire Alarm Code at 2-8.1 states each manual fire alarm box shall be securely mounted. The operable part of each manual fire alarm box shall be not less than 3 1/2 feet (42 inches) and not more than 4 1/2 feet (54 inches) above floor level. This deficient practice could affect approximately 25 residents who reside on the 2 North Hall, and any residents using the first floor beauty shop, in the Service Hall. Findings include: Based on observations on 10/31/11 during a tour of the facility from 8:00 a.m. to 1:10 p.m. with the maintenance	K0052	**K 052** Requires that a facility has: A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 The facility will ensure this requirement is met through the following: 1. No residents were harmed. Fire alarm boxes identified as a concern were lowered which include, the Service Hall pull station near beauty shop and the 2 West Hall pull station (noted on 2567 as 2 North Hall). 2. All residents have the potential to be affected. Facility inspected and no further areas of concern noted. 3. Maintenance staff in-serviced on K052. 4. The above plan of correction will be completed on or before November 30, 2011.	11/30/2011

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	supervisor and administrator, the first floor Service Hall fire alarm pull station box was mounted 67 inches from the floor and the second floor 2 North Hall pull station box was mounted 62 inches from the floor. This was verified by the maintenance supervisor and administrator at the time of observations. 3.1-19(b)			
K0054 SS=C	All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 1. Based on observation and interview, the facility failed to ensure 1 of 73 smoke detectors was not located where airflow could prevent the operation of the detector. LSC 9.6.1.3 says the provisions of 9.6 cover the basic functions of a fire alarm system and 9.6.1.4 refers to NFPA 72. NFPA 72, 2-3.5.1 requires, in spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice could affect any residents using the beauty shop in the first floor Service Corridor.	K0054	**K054** Requires that a facility has: All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 The facility will ensure this requirement is met through the following: 1. No residents were harmed. Koorseen Fire and Security moved the First Floor Service Hall smoke detector identified as a concern (See Attachment F). Additionally, # 16 and #17 smoke detectors were repaired (See Attachment F). 2. All residents have the potential to be affected. No further concerns noted. 3. Maintenance staff in-serviced on K054. 4. The Administrator or designee will utilize the Interior Preventative	11/30/2011

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	Findings include: Based on observation on 10/31/11 at 8:20 a.m. with the maintenance supervisor and administrator, the first floor Service Hall smoke detector near the mechanical room corridor was located one foot from a return air duct. This was verified by the maintenance supervisor and administrator at the time of observation. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure 2 of 73 smoke detectors tested for sensitivity were either cleaned and recalibrated or replaced. LSC 9.6.1.3 indicates provisions of 9.6 cover the basic functions of the fire alarm system, including fire detection systems. LSC 9.6.1.4 refers to NFPA 72, The National Fire Alarm Code. NFPA 72, at 7-3.2 requires testing in accordance with Table 7-3.2, Testing Frequencies. Table 7-3.2.15(i) refers to 7-3.2.1 which requires Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector had remained within its listed and marked		Maintenance Monitoring Tool monthly times 3 months and then Quarterly until compliance has been maintained for 2 consecutive quarters (See Attachment A). The audits will be reviewed during the facilities quality assurance meeting and issues will be addressed and the above plan will be altered accordingly, if needed. 5. The above plan of correction will be completed on or before November 30, 2011.	

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	sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the			

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	detector. This deficient practice affects all residents in the facility. Findings include: Based on a review of Koorsen Fire Alarm System Inspection and Testing Reports Quarterly on 10/31/11 at 12:00 p.m., the quarterly report dated 01/26/10 showed the # 16 smoke detector located by the phone service room and the # 17 smoke detector located at the nurses' station both failed sensitivity testing. Based on a review of the reports provided by the administrator dated 01/26/10, 04/12/10, 04/08/11, 07/11/11 and 08/11/11, there was no evidence provided the two failed smoke detectors were replaced. This was verified by the maintenance supervisor and administrator at the time of record review. 3.1-19(b)			
K0062 SS=F	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 1. Based on observations and interview, the facility failed to ensure 1 of 4 stairway exits and 1 of 163 rooms were provided	K0062	**K 062** Requires that a facility has: Required automatic sprinkler systems are continuously maintained in reliable operating	11/30/2011

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	with sprinkler heads free of paint. 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2-2.1.1 requires sprinklers to be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (upright, pendent, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 12 residents who reside on the second floor 400 Hall and would use the 2 East stairway during an evacuation. Findings include: Based on observation on 10/31/11 at 11:10 a.m. with the maintenance supervisor and administrator, the second floor 2 East exit stairway had two sprinklers covered with yellow paint, and the soiled linen room across the corridor from the 2 East stairway had one sprinkler covered with white paint. This was verified by the administrator and maintenance supervisor at the time of observation. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure a stock of at least 6 spare sprinklers were stored in a cabinet on the premises for replacement purpose. NFPA 101 Section 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based		condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 The facility will ensure this requirement is met through the following: 1. No residents were harmed. Sprinklers identified as a concern have been corrected. 2. Paint was removed from the second floor 2 East exit stairway and the soiled linen room across from the 2 East stairway. All other sprinkler heads were inspected for paint and no concerns noted. 3. Reserve stock of 6 sprinkler heads obtained . 4. Zip strip ties were removed from sprinklers in the Central Supply Room and hangers on existing pipe were removed and corrected. **5.** All sprinkler gauges found in need of replacement were replaced. (See Attachment H). 6. The two sprinkler head escutcheons in the Beauty Shop identified as a concern have been addressed and are flush to the ceiling. All other escutcheons have been inspected and no other concerns noted. 7. The Sprinkler System was inspected by Brown Sprinkler and no other concerns noted (See Attachment G). 8. Maintenance staff was in-serviced on K062. 9. The Administrator or designee will utilize the Interior Preventative Maintenance Monitoring Tool monthly times 3 months and then Quarterly until compliance has been maintained for 2 consecutive quarters (See	

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	Fire Protection Systems. NFPA 25, 2-4.1.4 requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purpose. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. The cabinet shall be so located so it will not be exposed to moisture, dust, corrosion, or a temperature exceeding 100 degrees F (38 degrees C). This deficient practice affects all residents in the facility. Findings include: Based on observation on 10/31/11 at 10:45 a.m. with the maintenance supervisor and administrator, the first floor sprinkler riser room lacked a cabinet with a supply of spare sprinklers. This was verified by the maintenance supervisor and administrator at the time of observation. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems. NFPA 13, 6-1.1.5 requires sprinkler piping or hangers shall not be used to support nonsystem components. This deficient practice could affect any		Attachment A). The audits will be reviewed during the facilities quality assurance meeting and issues will be addressed and the above plan will be altered accordingly, if needed. 10. The above plan of correction will be completed on or before November 30, 2011.	

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	residents using the Administration Hall near the central supply room. Findings include: Based on observation on 10/31/11 at 11:50 a.m. with the maintenance supervisor and administrator, the Administration Hall central supply room had a new two inch sprinkler pipe which ran along the east wall to the bathroom with four sprinkler pipe hangers attached to the original sprinkler pipe supplying sprinkler coverage in the east side of the central supply room. Furthermore, the west side of the central supply room had a two inch sprinkler pipe with zip strip ties used to tie down telephone lines along the twenty foot length of sprinkler pipe. This was verified by the maintenance supervisor and administrator at the time of observation. 3.1-19(b) 4. Based on observation, record review and interview; the facility failed to ensure 1 of 1 sprinkler systems was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3			

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	percent of the full scale shall be recalibrated or replaced. This deficient practice affects all occupants in the facility including staff, visitors and residents. Findings include: Based on observation with the maintenance supervisor and administrator on 10/31/11 at 9:10 a.m., the sprinkler system riser located in the first floor fire alarm system room had four pressure gauges without a date indicating when the gauges were manufactured. Based on a review of Brown Sprinkler System Quarterly Inspection Reports from 01/12/2003 to 11/29/11 which occurred on 10/31/11 at 12:00 p.m., there was no indication the four sprinkler system pressure gauges were recalibrated or replaced over the past eight years. This was verified by the maintenance supervisor and administrator at the 12:00 p.m. review of the Brown Sprinkler System Quarterly Inspection Reports on 10/31/11. 3.1-19(b) 5. Based on observation and interview, the facility failed to ensure 2 of over 300 sprinkler heads in the facility were maintained. This deficient practice could			

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	affect any residents who use the first floor Service Hall beauty shop. Findings include: Based on observation on 10/31/11 at 9:40 a.m. with the maintenance supervisor and administrator, the two sprinkler head escutcheons in the beauty shop were not flush to the ceiling leaving a one inch to three inch gap into the attic space above the drop ceiling assembly. This was acknowledged by the maintenance supervisor and administrator at the time of observation. 3.1-19(b)			
K0064 SS=E	Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 18 portable fire extinguishers was installed correctly. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.10 requires the top of portable fire extinguishers weighing 40 pounds or less should be no more than five feet (60 inches) above the floor and those weighing more than 40 pounds should be not more than three and one half feet (42 inches) above the floor. This deficient practice could affect any	K0064	**K 064** Requires that a facility has: Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 The facility will ensure this requirement is met through the following: 1. No residents were harmed. The fire extinguisher located in the first floor lounge identified as a concern was lowered. 2. All residents have the potential to be affected. All other fire extinguishers were inspected and no further problems noted. 3.	11/30/2011

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	residents using the first floor lounge. Findings include: Based on observation on 10/31/11 at 10:10 a.m. with the maintenance supervisor and administrator, the first floor lounge fire extinguisher measured sixty six inches from the top of the extinguisher to the floor. This was verified by the maintenance supervisor and administrator at the time of observation. 3.1-19(b)		Maintenance staff in-serviced on K064. 4. The Administrator or designee will utilize the Interior Preventative Maintenance Monitoring Tool monthly times 3 months and then Quarterly until compliance has been maintained for 2 consecutive quarters (See Attachment A). The audits will be reviewed during the facilities quality assurance meeting and issues will be addressed and the above plan will be altered accordingly, if needed. 5. The above plan of correction will be completed on or before November 30, 2011.	
K0130 SS=E	OTHER LSC DEFICIENCY NOT ON 2786 Based on observation, interview and record review; the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure.	K0130	**K 130** Requires that a facility: MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 The facility will ensure this requirement is met through the following: 1. No residents were harmed. Rolling fire door will be inspected on or before November 30 th , 2011. 2. All residents have the potential to be affected. No other concerns noted. 3. Maintenance staff in-serviced on K130. 4. The Rolling Fire Door was added to the facility Preventative Maintenance Program (See Attachment I). 5. The Administrator or designee will utilize the Interior Preventative Maintenance Monitoring Tool monthly times 3 months and then	11/30/2011

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	Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect any residents who use the main dining room, located adjacent to the kitchen. Findings include: Based on observation on 10/31/11 at 9:50 a.m. with the maintenance supervisor and administrator, there was a rolling fire door protecting the opening from the kitchen to the main dining room without an attached inspection tag. Based on interview on 10/31/11 and subsequent Fire Safety record review at 12:45 p.m. with the maintenance supervisor and administrator, it was acknowledged there was no additional documentation of an annual inspection or test to check for proper operation and full closure of the vertical rolling fire door located in the kitchen opening to the main dining room. 3.1-19(b)		Quarterly until compliance has been maintained for 2 consecutive quarters (See Attachment A). The audits will be reviewed during the facilities quality assurance meeting and issues will be addressed and the above plan will be altered accordingly, if needed. 6. The above plan of correction will be completed on or before November 30, 2011.	
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.			

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	1. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 24 of 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. 6-4.1 requires Level 1 and Level 2 EPSS, including all appurtenant components, shall be inspected weekly and shall be exercised under load monthly at a minimum. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the maintenance supervisor and administrator on 10/31/11 at 12:20 p.m., there was no	K0144	**K 144** Requires that a facility: Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. The facility will ensure this requirement is met through the following: 1. No residents were harmed. Generator testing completed (See Attachment J).2. All residents have the potential to be affected. No other concerns noted. 3. The current Preventative Maintenance Program for the Emergency Generator was reviewed with no changes (See Attachment K). 4. Maintenance staff in-serviced on K144. 5. The Administrator or designee will utilize the Interior Preventative Maintenance Monitoring Tool monthly times 3 months and then Quarterly until compliance has been maintained for 2 consecutive quarters (See Attachment A). The audits will be reviewed during the facilities quality assurance meeting and issues will be addressed and the above plan will be altered accordingly, if needed. 6. The above plan of correction will be completed on or before November 30, 2011.	11/30/2011

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	record of weekly storage battery tests and weekly inspections of the generator set for the months of October 2010, November 2010, December 2010, January 2011, July 2011, and September 2011. Additionally, based on interview during the record review, the administrator stated there was no other documentation available for review to verify these weekly generator inspections were conducted. 3.1-19(b) 2. Based on record review and interview, for 6 of 12 months the facility failed to exercise the generator to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions			

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	or at not less than 30 percent of the EPS nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors. Findings include: Based on interview and review of the Generator Testing Log with the maintenance supervisor and administrator on 10/31/11 at 12:30 p.m., there was no record of a monthly load test for the months of October 2010, November 2010, December 2010, January 2011, July 2011, and September 2011. Additionally, based on interview during the record review, the administrator stated there was no other documentation available for review to verify these monthly load tests on the generator were conducted. 3.1-19(b) 3. Based on observation and interview, the facility failed to provide adequate emergency task lighting in and around the generator set in accordance with NFPA			

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	101, 2000 Edition, Life Safety Code. LSC Section 7.9.2.3 requires that emergency generators providing power to emergency lighting systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110 Section 5-3.1 requires that the EPS (Emergency Power Supply) equipment location shall be provided with battery-powered emergency lighting. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation with the maintenance supervisor and administrator on 10/31/11 at 11:50 a.m., the emergency generator located outside and to the west of the basement west physical therapy room, was housed in a metal fence with a plastic cover over the fencing. The area where the emergency generator was housed lacked battery backup lighting. This was verified by the maintenance supervisor and administrator at the time of observation. 3.1-19(b)			
K0147 SS=E	Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2			

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	Based on observation and interview, the facility failed to ensure extension cords including powerstrips and non-fused multiplug adapters were not used as a substitute for fixed wiring in 5 of 163 rooms. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.1 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect any residents using the first floor respiratory therapy office, and the payroll office, any residents using the first floor beauty shop, 2 residents who reside in room 112, and 2 residents who reside in room 315. Findings include: Based on observations on 10/31/11 during a tour of the facility from 8:00 am to 1:10 p.m. with the maintenance supervisor and administrator, the first floor respiratory therapy office and payroll office each had a fifty foot orange extension cord in use powering a computer and printer. Furthermore, the following rooms used high current draw electrical equipment plugged in to power strips; a. The first floor beauty shop had a hair dryer	K0147	**K 147** Requires that a facility: Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 The facility will ensure this requirement is met through the following: 1. No residents were harmed. All cords identified as a concern were removed. 2. All residents have the potential to be affected. No other concerns noted. 3. Maintenance in-serviced on K147. 4. Policy for extension cord and power strip usage was reviewed with no changes made (See Attachment L). 5. The Administrator or designee will utilize the Interior Preventative Maintenance Monitoring Tool monthly times 3 months and then Quarterly until compliance has been maintained for 2 consecutive quarters (See Attachment A). The audits will be reviewed during the facilities quality assurance meeting and issues will be addressed and the above plan will be altered accordingly, if needed. 6. The above plan of correction will be completed on or before November 30, 2011.	11/30/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155203	A. BUILDING 02 B. WING	10/31/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CENTRE FOR HEALTH AND REHABILITATION	203 SPARKS AVE JEFFERSONVILLE, IN47130

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	plugged in to a power strip. b. The first floor respiratory therapy office had a refrigerator plugged in to a power strip. c. Resident room 112 had a refrigerator plugged in to a power strip. d. Resident room 315 had two refrigerators plugged in to a power strip. Based on an interview with the maintenance supervisor and administrator on 10/31/11 at the 1:10 p.m. exit conference, the facility did not have a written policy for the use of power strips. 3.1-19(b)			